STATEMENT OF EMERGENCY

907 KAR 1:170E

(1) This emergency administrative regulation is being promulgated to establish a new category of home and community based waiver service provider, a safety net provider, along with a corresponding enhanced reimbursement.

(2) This action must be taken on an emergency basis to protect the health, safety and welfare of HCB recipients by ensuring access to necessary care.

(3) This emergency administrative regulation shall be replaced by an ordinary administrative regulation filed with the Regulations Compiler.

(4) The ordinary administrative regulation differs from this emergency administrative regulation as it does not contain the lump-sum payment provision established in Section 5 of this emergency administrative regulation. The lump-sum payment shall be paid under the authority of this emergency administrative regulation and duplication could potentially occur if the provision was also included in the ordinary administrative regulation.

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Steven L. Beshear,
Governor

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Janie Miller, Secretary
Cabinet for Health and Family Services

CABINET FOR HEALTH AND FAMILY SERVICES

Department for Medicaid Services

Division of Community Alternatives

(Emergency Amendment)

907 KAR 1:170E. Reimbursement for home and community based waiver services.

RELATES TO: 42 C.F.R. 441 Subparts B, G, 42 U.S.C. 1396a, b, d, n

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3)

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services, is required to administer the Medicaid Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with any requirement that may be imposed, or opportunity presented, by federal law for the provision of medical assistance to Kentucky's indigent citizenry. This administrative regulation establishes the method for determining amounts payable by the Medicaid Program for services provided by home and community based waiver service providers to an eligible recipient as an alternative to nursing facility care.

Section 1. Definitions. (1) "ADHC" means adult day health care.

(2) "ADHC center" means an adult day health care center that is:

(a) Licensed in accordance with 902 KAR 20:066, Section 4; and

(b) Certified for Medicaid participation by the department.

(3) "Cost report" means the Home Health and Home and Community Based Cost Report and the Home Health and Home and Community Based Cost Report Instructions.

(4) "DD" means developmentally disabled.

(5) "Department" means the Department for Medicaid Services or its designee.

(6) "Fixed upper limit" means the maximum amount the department shall reimburse for a unit of service.

(7) "HCB" means home and community based waiver.

(8) "HCB recipient" means an individual who:

(a) Meets the criteria for a recipient as defined in KRS 205.8451; and

(b) Meets the criteria for HCB services as established in 907 KAR 1:160.

(9) "Level I" means a reimbursement rate paid to an ADHC center for a basic unit of service provided by the ADHC center to an individual designated as an HCB recipient.

(10) "Level II" means a reimbursement rate of paid to an ADHC center for a basic unit of service provided by the ADHC center to an individual designated as an HCB recipient, if the ADHC center meets the criteria established in Sections 5 and 6 of this administrative regulation.

(11) "Medically necessary" or "medical necessity" means that a covered benefit is determined to be needed in accordance with 907 KAR 3:130.

(12) “Metropolitan Statistical Area” means the designation of an urban population center based on the national census and updated on a yearly basis as published by the United States Office of Management and Budget.

(13) “Nonprofit organization” means a legally constituted organization under the Internal Revenue Service code whose objective is to support or engage in activities of public or private interest without any commercial or monetary profit.

(14) "Occupational therapist" is defined by KRS 319A.010(3).

(15)[~~(13)~~] "Occupational therapist assistant" is defined by KRS 319A.010(4).

(16)[~~(14)~~] "Physical therapist" is defined by KRS 327.010(2).

(17)[~~(15)~~] "Physical therapist assistant" means a skilled health care worker who:

(a) Is certified by the Kentucky Board of Physical Therapy; and

(b) Performs physical therapy and related duties as assigned by the supervising physical therapist.

(18)[~~(16)~~] "Quality improvement organization" or QIO is defined in 42 C.F.R. 475.101.

(19) “Revenue code service” means:

(a) An assessment, reassessment, homemaking, personal care, respite or attendant care service; or

(b) A minor home adaptation.

(20) “Safety net provider” means a provider which:

(a) Provides 100,000 or more units of revenue code services per year;

(b) Provides revenue code services in an area that is not a Metropolitan Statistical Area of the commonwealth; and

(c) Is a nonprofit organization.

(21)[~~(17)~~] "Speech-language pathologist" is defined by KRS 334A.020(3).

Section 2. HCB Service Reimbursement. (1) Except as provided in Section 3, 4 or 5 [~~3 or 4~~] of this administrative regulation, the department shall reimburse for a home and community based waiver service provided in accordance with 907 KAR 1:160 at the lesser [~~lessor~~] of billed charges or the fixed upper payment rate for each unit of service. The following rates shall be the fixed upper payment rate limits:

Home and Community Based Waiver Service	Fixed Upper Payment Rate Limit	Unit of Service
Assessment	$100.00	Entire assessment process
Reassessment	$100.00	Entire reassessment process
Case Management	$15.00	15 minutes
Homemaking	$13.00	30 minutes
Personal Care	$15.00	30 minutes
Attendant Care	$11.50	1 hour (not to exceed 45 hours per week)
Respite	$2,000 per 6 months (January 1 through June 30 and July 1 through December 31, not to exceed $4,000 per calendar year)	1 hour
Minor Home Adaptation	$500 per calendar year	

(2) A service listed in subsection (1) of this section shall not be subject to cost settlement by the department unless provided by a local health department.

(3) A homemaking service shall be limited to no more than four (4) units per week per HCB recipient.

Section 3. Local Health Department HCB Service Reimbursement. (1) The department shall reimburse a local health department for HCB services:

(a) Pursuant to Section 2 of this administrative regulation; and

(b) Equivalent to the local health department's HCB services cost for a fiscal year.

(2) A local health department shall submit a cost report to the department at fiscal year's end.

(3) The department shall determine, based on a local health department's most recently submitted annual cost report, the local health department's estimated costs of providing HCB services by multiplying the cost per unit by the number of units provided during the period.

(4) If a local health department HCB service reimbursement for a fiscal year is less than its cost, the department shall make supplemental payment to the local health department equal to the difference between:

(a) Payments received for HCB services provided during a fiscal year; and

(b) The estimated cost of providing HCB services during the same time period.

(5) If a local health department's HCB service cost as estimated from its most recently submitted annual cost report is less than the payments received pursuant to Section 2 of this administrative regulation, the department shall recoup any excess payments.

(6) The department shall audit a local health department's cost report if it determines an audit is necessary.

Section 4. Safety Net Provider Standard Reimbursement. (1) The department shall reimburse for a revenue code service provided by a safety net provider a rate equal to the median rate of all local health departments for the revenue code service.

(2) The median rate referenced in subsection (1) of this section shall be the median rate subsequent to any supplemental payment pursuant to Section 3(4) or recoupment pursuant to Section 3(5) of this administrative regulation.

Section 5. Safety Net Provider Lump Sum Payment. (1) The department shall make a one-time lump sum payment to a safety net provider equal to what reimbursement would have been at the safety net provider rate established in Section 4(1) of this administrative regulation for a revenue code service provided from July 1, 2008 – had the rate been effective July 1, 2008 - until the effective date of this emergency administrative regulation minus what the department has already paid or owes (via the pre-safety net provider reimbursement) the provider for services provided from July 1, 2008 until the effective date of this emergency administrative regulation.

Section 6. Reimbursement for an ADHC Service. (1) Reimbursement shall:

(a) Be made:

1. Directly to an ADHC center; and

2. For a service only if the service was provided on site and during an ADHC center's posted hours of operation;

(b) If made to an ADHC center for a service not provided during the center's posted hours of operation, be recouped by the department; and

(c) Be limited to 120 units per calendar week at each HCB recipient's initial review or recertification.

(2) Level I reimbursement shall be the lesser of the provider's usual and customary charges or two (2) dollars and fifty-seven (57) cents per unit of service.

(3) Level II reimbursement shall be the lesser of the provider's usual and customary charges or three (3) dollars and twelve (12) cents per unit of service.

(4) The department shall not reimburse an ADHC center for more than twenty-four (24) basic units of service per day per HCB recipient.

(5) An ADHC basic daily service shall:

(a) Constitute care for one (1) HCB recipient; and

(b) Not exceed twenty-four (24) units per day.

(6) One (1) unit of ADHC basic daily service shall equal fifteen (15) minutes.

(7) An ADHC center may request a Level II reimbursement rate for an HCB recipient if the ADHC center meets the following criteria:

(a) The ADHC center has an average daily census limited to individuals designated as:

1. HCB recipients;

2. Private pay; or

3. Covered by insurance; and

(b) The ADHC center has a minimum of eighty (80) percent of its individuals meeting the requirements for DD as established in Section 5(2) of this administrative regulation.

(8) If an ADHC center does not meet the Level II requirements established in Section 5 of this administrative regulation, the ADHC center shall be reimbursed at a Level I payment rate for the quarter for which the ADHC center requested Level II reimbursement.

(9) To qualify for Level II reimbursement, an ADHC center that was not a Medicaid provider before July 1, 2000 shall:

(a) Have an average daily census of at least twenty (20) individuals who meet the criteria established in subsection (2)(a) of this section; and

(b) Have a minimum of eighty (80) percent of its individuals meet the description of DD as established in Section 5(2) of this administrative regulation.

(10) To qualify for reimbursement as an ancillary therapy, a service shall be:

(a) Medically necessary;

(b) Ordered by a physician; and

(c) Limited to:

1. Physical therapy provided by a physical therapist or physical therapist assistant;

2. Occupational therapy provided by an occupational therapist or occupational therapist assistant; or

3. Speech therapy provided by a speech-language pathologist.

(11) Ancillary therapy service reimbursement shall be:

(a) Per HCB recipient per encounter; and

(b) The usual and customary charges not to exceed the Medicaid upper limit of seventy-five (75) dollars per encounter per HCB recipient.

(12) A respite service shall:

(a) Be provided on site in an ADHC center; and

(b) Be provided pursuant to 907 KAR 1:160.

(13) One (1) respite service unit shall equal one (1) hour to one (1) hour and fifty-nine (59) minutes.

(14) The length of time an HCB recipient receives a respite service shall be documented.

(15) A covered respite service shall be reimbursed as established in Section 2 of this administrative regulation.

Section 7.[~~5.~~] Criteria for DD ADHC Level II Reimbursement. To qualify for Level II reimbursement:

(1) An ADHC center shall meet the requirements established in Section 4 of this administrative regulation; and

(2) Eighty (80) percent of its ADHC service individuals shall have:

(a) A substantial disability that shall have manifested itself before the individual reaches twenty-two (22) years of age;

(b) A disability that is attributable to mental retardation or a related condition which shall include:

1. Cerebral palsy;

2. Epilepsy;

3. Autism; or

4. A neurological condition that results in impairment of general intellectual functioning or adaptive behavior, such as mental retardation, which significantly limits the individual in two (2) or more of the following skill areas:

a. Communication;

b. Self-care;

c. Home-living;

d. Social skills;

e. Community use;

f. Self direction;

g. Health and safety;

h. Functional academics;

i. Leisure; or

j. Work; and

(c) An adaptive behavior limitation similar to that of a person with mental retardation, including:

1. A limitation that directly results from or is significantly influenced by substantial cognitive deficits; and

2. A limitation that is not attributable to only a physical or sensory impairment or mental illness.

Section 8.[~~6.~~] The Assessment Process for Level II ADHC Reimbursement. (1) To apply for Level II ADHC reimbursement, an ADHC center shall contact the QIO on the first of the month prior to the end of the current calendar quarter. If the first of the month is on a weekend or holiday, the ADHC center shall contact the QIO the next business day.

(2) The QIO shall be responsible for randomly determining the date each quarter for conducting a Level II assessment of an ADHC center.

(3) In order for an ADHC center to receive Level II reimbursement:

(a) An ADHC center shall:

1. Document on a MAP-1021 form that it meets the Level II reimbursement criteria established in Section 5 of this administrative regulation;

2. Submit the completed MAP-1021 form to the QIO via facsimile or mail no later than ten (10) working days prior to the end of the current calendar quarter in order to be approved for Level II reimbursement for the following calendar quarter; and

3. Attach to the MAP-1021 form a completed and signed copy of the "Adult Day Health Care Attending Physician Statement" for each individual listed on the MAP-1021 form;

(b) The QIO shall review the MAP-1021 form submitted by the ADHC center and determine if the ADHC center qualifies for Level II reimbursement; and

(c) The department shall review a sample of the ADHC center's Level II assessments and validate the QIO's determination.

(4) If the department invalidates an ADHC center Level II reimbursement assessment, the department shall:

(a) Reduce the ADHC center's current rate to the Level I rate; and

(b) Recoup any overpayment made to the ADHC center.

(5) If an ADHC center disagrees with an invalidation of a Level II reimbursement determination, the ADHC center may appeal in accordance with 907 KAR 1:671, Sections 8 and 9.

Section 9.[~~7.~~] Appeal Rights. An HCB service provider may appeal a department decision as to the application of this administrative regulation as it impacts the provider's reimbursement in accordance with 907 KAR 1:671, Sections 8 and 9.

Section 10.[~~9.~~] Incorporation by Reference. (1) The following material is incorporated by reference:

(a) "Map-1021, ADHC Payment Determination Form", August 2000 Edition;

(b) "Adult Day Health Care Attending Physician Statement", August 2000 Edition;

(c) "The Home Health and Home and Community Based Cost Report", November 2007 Edition; and

(d) "The Home Health and Home and Community Based Cost Report Instructions", November 2007 Edition.

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Department for Medicaid Services, 275 East Main Street, Frankfort, Kentucky 40601, Monday through Friday, 8 a.m. to 4:30 p.m. (Recodified from 904 KAR 1:170, 5-2-86; Am. 13 Ky.R. 1515; eff. 3-6-87; 15 Ky.R. 689; eff. 9-21-88; 16 Ky.R. 2606; eff. 6-27-90; 24 Ky.R. 782; 1103; eff. 11-14-97; 27 Ky.R. 1626, 2175; eff. 2-1-2001; 29 Ky.R. 1136, 1653; eff. 12-18-02; 30 Ky.R. 460; 883; eff. 10-31-03; 33 Ky.R. 597; 1326; eff. 12-1-06; 34 Ky.R. 442; 1036; 1465; eff. 1-4-2008.)

907 KAR 1:170E

REVIEWED:

Date	Elizabeth A. Johnson, Esq., Commissioner Department for Medicaid Services

APPROVED:

Date	Janie Miller, Secretary Cabinet for Health and Family Services

REGULATORY IMPACT ANALYSIS
AND TIERING STATEMENT

Administrative Regulation #: 907 KAR 1:170E
Cabinet for Health and Family Services
Department for Medicaid Services
Agency Contact Person: Stuart Owen (502) or Ked Fitzpatrick (502) 564-8196

(1) Provide a brief summary of:
(a) What this administrative regulation does: This administrative regulation establishes provisions related to home and community based (HCB) waiver service reimbursement.
(b) The necessity of this administrative regulation: This administrative regulation is necessary to establish provisions related to home and community based (HCB) waiver service reimbursement.
(c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation conforms to the content of the authorizing statutes by establishing provisions related to home and community based (HCB) waiver service reimbursement
(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation assists in the effective administration of the statutes by establishing provisions related to home and community based (HCB) waiver service reimbursement.

(2) If this is an amendment to an existing administrative regulation, provide a brief summary of:
(a) How the amendment will change this existing administrative regulation: The amendment establishes a new category of service provider, safety net provider, along with a corresponding enhanced reimbursement.
(b) The necessity of the amendment to this administrative regulation: This amendment is necessary to ensure adequate access to services for rural HCB service recipients.
(c) How the amendment conforms to the content of the authorizing statutes: This amendment conforms to the content of the authorizing statutes by ensuring adequate access to services for HCB recipients in rural areas.
(d) How the amendment will assist in the effective administration of the statutes: This amendment will assist in the effective administration of the authorizing statutes by ensuring adequate access to services for HCB recipients in rural area.

(3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: The Department for Medicaid Services anticipates that one (1) entity will qualify as a safety net provider.

(4) Provide an analysis of how the entities identified in question (3) will be impacted

by either the implementation of this administrative regulation, if new, or by the change, if it is an amendment, including:

(a) List the actions that each of the regulated entities identified in question (3) will have to take to comply with this administrative regulation or amendment. The amendment establishes a new category of service provider, safety net provider, along with a corresponding enhanced reimbursement and does not require provider compliance action.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3). This amendment does not impose a cost on regulated entities.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3). Reimbursement is enhanced for a safety night provider which in turn also ensures access to services for HCB recipients in rural areas.

(5) Provide an estimate of how much it will cost to implement this administrative regulation:

(a) Initially: The Department for Medicaid Services (DMS) anticipates that the amendment will cost approximately $500,000 ($350,000 federal funds and $150,000 state funds) annually.

(b) On a continuing basis: DMS anticipates that the amendment will cost approximately $500,000 ($350,000 federal funds and $150,000 state funds) annually.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: The sources of revenue to be used for implementation and enforcement of this administrative regulation are federal funds authorized under Title XIX of the Social Security Act and matching funds from general fund appropriations.

(7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment: Neither an increase in fees nor funding will be necessary to implement this administrative regulation.

(8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: This amendment does not establish any fees or directly or indirectly increase any fees.

(9) Tiering: Is tiering applied? (Explain why tiering was or was not used)
Tiering is applied in that an entity must qualify as a safety net provider to receive the new enhanced reimbursement. A safety net provider's viability is necessary to promote adequate access to HCB services for recipients located in rural areas.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

Reg NO: 907 KAR 1:170E Contact Person: Stuart Owen (502) 564-6204 or Ked Fitzpatrick (502) 564-8196

1. Does this administrative regulation relate to any program, service, or requirements of a state or local government (including cities, counties, fire departments or school districts)?

   Yes _X__ No ____
   If yes, complete 2-4.

2. What units, parts or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? The Department for Medicaid Services anticipates that it, a state government entity, will be impact in that the amendment is projected to cost approximately $500,000 ($350,000 federal funds/$150,000 state funds) annually.

3. Identify each state or federal regulation that requires or authorizes the action taken by the administrative regulation. This amendment is authorized by KRS 194A.030(2), 194A.050(1) and 205.520(3).

4. Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect.

   (a) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? DMS does not expect the amendment to generate revenue for state or local government.

   (b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years. DMS does not expect the amendment to generate revenue for state or local government

   (c) How much will it cost to administer this program for the first year? DMS anticipates that the amendment will cost approximately $500,000 ($350,000 federal funds and $150,000 state funds) annually.

   (d) How much will it cost to administer this program for subsequent years? DMS anticipates that the amendment will cost approximately $500,000 ($350,000 federal funds and $150,000 state funds) annually.

Note: If specific dollar estimates cannot be determined, provide a brief narrative to explain the fiscal impact of the administrative regulation.

Revenues (+/-):

Expenditures (+/-):